Filing at a Glance

Company:	Combined Insurance Company of America
Product Name:	146500R-DC - Critical Illness
State:	District of Columbia
TOI:	H07I Individual Health - Specified Disease - Limited Benefit
Sub-TOI:	H07I.001 Critical Illness
Filing Type:	Form
Date Submitted:	11/10/2016
SERFF Tr Num:	ACEH-130802461
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	16-AH-2013652
Implementation Date Requested:	On Approval
Author(s):	Deborah Shortridge, Marivic Chiong
Reviewer(s):	Colin Johnson (primary), Andre Beard
Disposition Date:	
Disposition Status:	
Implementation Date:	

General Information

Project Name: 16-AH-2013652
Project Number: 16-AH-2013652
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Deborah Shortridge

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Similar forms were filed with our domicile state, Illinois, on September 9, 2016.

Market Type: Individual
Individual Market Type:
Filing Status Changed: 11/10/2016
State Status Changed:
Created By: Deborah Shortridge
Corresponding Filing Tracking Number:

Filing Description:
Combined Insurance Company of America
FEIN Number: 36-2136262
NAIC Number: 626-62146
Form No. 146500R-DC - Critical Illness Application
Form No. 146700R-DC - Cancer Only Application
Individual A&H
FILING SUBMITTED FOR REVIEW & APPROVAL

This is a new filing. Form Nos. 146500R-DC and 146700R-DC was previously approved under SERFF Tracking Number ACEH-130764879 on October 28, 2016. These forms are identical to the previously approved forms except that we have removed the sentence “If coverage applied for includes Sickness Rider, please complete the attestation below (If the Proposed Insured checks “No”, the Sickness Rider will not be issued).” Redlines copies of the forms are attached for your information.

These forms have not been implemented and will replace our prior filing that was approved under SERFF Tracking Number ACEH-130764879 on October 28, 2016.

Application Form No. 146500R-DC will be used with Critical Illness Policy, Form No. 16660-DC and its associated forms which were approved on November 16, 2015 under SERFF Tracking No.ACEH-130010408. Application Form No. 146700R-DC will be used with the Cancer Only Policy, Form No. 16738-DC and its associated forms which were approved on November 16, 2015 under SERFF Tracking No.ACEH-130010408.

The Conditional Receipt that will be used with Application Form Nos. 146500R-DC and 146700R-DC is Form No. 164035R-1H, has been approved on January 15, 2015, under SERFF Tracking No.ACEH-129882918.

The application forms will be completed and/or transmitted either by paper or through electronic means. We certify that we will comply with your state's statutes regarding privacy and electronic signatures.

A Variability Memorandum for each application form explaining the bracketed items are included for your reference.

The forms are in final printed format. However, it is possible that actual issued forms may have different format and font style (but not the type size) as a result of different computer publishing systems. Therefore, page breaks may occur at different lines. We do not anticipate refiling for typographical errors, format changes or font style variations.

State: *District of Columbia* ***Filing Company:*** *Combined Insurance Company of America*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *146500R-DC - Critical Illness*
Project Name/Number: *16-AH-2013652/16-AH-2013652*

We appreciate your time in reviewing this filing. Please feel free to call me at our toll free number or email me if you have further questions or need additional information.

Company and Contact

Filing Contact Information

Deborah Shortridge, Senior Policy Analyst
1000 Milwaukee Ave
Glenview, IL 60025

deborah.shortridge@combined.com
847-953-1534 [Phone]
847-953-1557 [FAX]

Filing Company Information

Combined Insurance Company of America
1000 North Milwaukee Ave.
Glenview, IL 60025
(847) 953-2025 ext. [Phone]

CoCode: 62146
Group Code: 626
Group Name: Chubb
FEIN Number: 36-2136262

State of Domicile: Illinois
Company Type: A&H
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*ACEH-130802461*	***State Tracking #:***		***Company Tracking #:***	*16-AH-2013652*

State:	*District of Columbia*	***Filing Company:***	*Combined Insurance Company of America*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*146500R-DC - Critical Illness*		
Project Name/Number:	*16-AH-2013652/16-AH-2013652*		

Form Schedule

Lead Form Number: 16-AH-2013652

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Critical Illness Application	146500R-DC	AEF	Initial		50.850	146500R-DC.pdf
2		Cancer Only Application	146700R-DC	AEF	Initial		51.930	146700R-DC.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Bar Code] [Application Number] **[5 9 0 1]**

COMBINED INSURANCE COMPANY OF AMERICA

Home Office: [Chicago, Illinois]

Application for Critical Illness Coverage

[LANGUAGE PREFERENCE [☐ E] [☐ S] [☐ F]]

I am applying for this coverage based on the following information:

(Home Office Use)

[ACTION REQUESTED: **[** ☐ New Policy] [☐ Policy Change] [☐ Reinstatement]]

Proposed Insured's Name (First MI Last)	☐ Male ☐ Female	Birthdate: MM/DD/YYYY	Age
Proposed Insured's Home Address (Street)	City	State	Zip
[Landline Phone Number] [Mobile Phone Number]	[Email]		
Employer Name	[Work Phone Number]		
Employer Address (Street)	City	State	Zip
Beneficiary's Full Name		Relationship	
Beneficiary's Address (Street)	City	State	Zip
Billing Address *if different than residence (Street)*	City	State	Zip

Will this policy replace any existing policies for the Proposed Insured? ☐ Yes ☐ No

[Is the Proposed Insured's household income [$15,000] per year or more? ☐ Yes ☐ No]
[If "No", the Proposed Insured is not eligible for coverage.]

In the past [12 months], has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine or tobacco products? ☐ Yes ☐ No	Height _____FT. ___IN.	Weight _____LBS.

QUALIFICATION QUESTIONS:

I represent that the answers to the below questions are accurate and complete to the best of my knowledge and belief.

	Yes	No
1. Within the past [10 years], has the Proposed Insured received any medical advice or treatment from a member of the medical profession, or taken any prescription medicine for:		
a. Heart failure, angina, stroke, transient ischemic attack, heart attack, chronic atrial fibrillation, coronary artery disease that required angioplasty or stent placement, heart valve repair or replacement?	☐	☐
b. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?		
c. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?	☐	☐
d. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?	☐	☐
e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?	☐	☐
f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction?	☐	☐
g. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?	☐	☐
2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?	☐	☐
3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole, incarcerated or convicted of a felony?	☐	☐
4. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?	☐	☐
5. [Within the past [6 months] has the Proposed Insured submitted an application for [life,] [or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	☐	☐

If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.

UNDERWRITING INFORMATION

	Yes	No
Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?	☐	☐

If "Yes", please provide details below:

Medical/Diagnostic Test	Diagnosis	Treatment	Dates	Physician Name/ Address/Phone No.

PLAN SELECTION

COVERAGE TYPE	*FACE AMOUNT* *(up to $50,000)*	*PAYMENT METHOD*	*PREMIUM AMOUNT*
[☐ Choice] [XXXXX] [XXX] [☐ Preferred] [XXXXX] [XXX]	$	[☐ Bi-weekly EFT] [☐ Monthly Credit Card] [☐ Monthly EFT] [☐ Quarterly Credit Card] [☐ Quarterly EFT] [☐ Semi-Annual Credit Card] [☐ Semi-Annual EFT] [☐ List Bill] [☐ Annual Bill] [☐ Other]	$

DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.

[2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? ☐ Yes ☐ No

If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.

(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? ☐ Yes ☐ No

(3) Do you understand that the benefits provided under this policy may be limited? ☐ Yes ☐ No

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]

X _____ _____ _____ _____
Signature of Proposed Insured | City | State | Date

I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me by the Proposed Insured, or have sent this application to the Proposed Insured and have received the completed and signed application on this date.

X _____ _____ _____
Signature of Licensed Agent/Producer | Agent Code | Date of Application

[Bar Code] [Application Number] **[6 1 0 1]**

COMBINED INSURANCE COMPANY OF AMERICA
Home Office: [Chicago, Illinois]

Application for Cancer Only Coverage
[LANGUAGE PREFERENCE [☐ E] [☐ S] [☐ F]]

I am applying for this coverage based on the following information:

(Home Office Use)

[ACTION REQUESTED: **[** ☐ New Policy] [☐ Policy Change] [☐ Reinstatement]]

Proposed Insured's Name (First MI Last)	☐ Male ☐ Female	Birthdate: MM/DD/YYYY	Age
Proposed Insured's Home Address (Street)	City	State	Zip
[Landline Phone Number] [Mobile Phone Number]	[Email]		
Employer Name	[Work Phone Number]		
Employer Address (Street)	City	State	Zip
Beneficiary's Full Name		Relationship	
Beneficiary's Address (Street)	City	State	Zip
Billing Address *if different than residence (Street)*	City	State	Zip

Will this policy replace any existing policies for the Proposed Insured? ☐ Yes ☐ No

[Is the Proposed Insured's household income [$15,000] per year or more? ☐ Yes ☐ No]
[If "No", the Proposed Insured is not eligible for coverage.]

In the past [12 months], has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine or tobacco products? ☐ Yes ☐ No	Height _____FT. ___IN.	Weight _____LBS.

QUALIFICATION QUESTIONS:
I represent that the answers to the below questions are accurate and complete to the best of my knowledge and belief.

	Yes	No
1. Within the past [10 years], has the Proposed Insured received any medical advice or treatment from a member of the medical profession, or taken any prescription medicine for:		
a. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?	☐	☐
b. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?	☐	☐
c. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?	☐	☐
d. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?	☐	☐
e. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?	☐	☐
2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?	☐	☐
3. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?	☐	☐
4. [Within the past [6 months] has the Proposed Insured submitted an application for [Cancer] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	☐	☐

If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.

[Bar Code] [Application Number] [6 1 0 2]

UNDERWRITING INFORMATION

Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes ☐ No ☐

If "Yes", please provide details below:

Medical/Diagnostic Test	Diagnosis	Treatment	Dates	Physician Name/ Address/Phone No.

PLAN SELECTION

COVERAGE TYPE	*FACE AMOUNT* *(up to $50,000)*	*PAYMENT METHOD*	*PREMIUM AMOUNT*
[☐ Choice] 16738 ECA	$	[☐ Bi-weekly EFT] [☐ Monthly EFT] [☐ Quarterly EFT] [☐ Semi-Annual EFT] [☐ Annual Bill] [☐ Monthly Credit Card] [☐ Quarterly Credit Card] [☐ Semi-Annual Credit Card] [☐ List Bill] [☐ Other]	$

DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.

[2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? Yes ☐ No ☐

If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.

(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? Yes ☐ No ☐

(3) Do you understand that the benefits provided under this policy may be limited? Yes ☐ No ☐

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]

X _____ _____ _____ _____

Signature of Proposed Insured | City | State | Date

I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me by the Proposed Insured, or have sent this application to the Proposed Insured and have received the completed and signed application on this date.

X _____ _____ _____

Signature of Licensed Agent/Producer | Agent Code | Date of Application

SERFF Tracking #:	*ACEH-130802461*	***State Tracking #:***		***Company Tracking #:***	*16-AH-2013652*

State:	*District of Columbia*	***Filing Company:***	*Combined Insurance Company of America*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*146500R-DC - Critical Illness*		
Project Name/Number:	*16-AH-2013652/16-AH-2013652*		

Supporting Document Schedules

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Vairability Memos
Comments:	
Attachment(s):	Variability Memo - 146500R.pdf Variability Memo - 146700R.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redline copies
Comments:	
Attachment(s):	146500R-DC DOI Redline 110916.pdf 146700R-DC DOI Redline 110916.pdf
Item Status:	
Status Date:	

READABILITY CERTIFICATION

Form Numbers:	146500R-DC	-	Critical Illness Application
	146700R-DC	-	Cancer Only Application

The above captioned form(s) have a Flesch Index Score of SEE BELOW and meet(s) the minimum reading ease requirements.

Form Nos.	Flesch Index Score
146500R-DC	50.85
146700R-DC	51.93

Marivic Chiong, Assistant Secretary

Marivic Chiong – Assistant Secretary / Manager - Product Filings/Government Relations/Law
Telephone: (847) 953-8359 Fax: (847) 953-1557 Toll Free: 888-449-3623 E-mail: Marivic.chiong@combined.com

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A Chubb Company

VARIABILITY MEMORANDUM
Individual Critical Illness Application Form

Application Form No. 146500R	
Home Office: [Chicago, Illinois]	Bracketed address to alleviate a future filing of these forms if the company addresses change.
[Language Preference [☐E] [☐S] [☐F]	
Action Requested: [New Policy], [Policy Change], Reinstatement]]	Bracketed to allow for company decision to remove if not needed for business operations.
[Landline Phone No.]	Bracketed to accommodate changes in technology and or phone terminology.
[Mobile Phone No.]	Bracketed to accommodate changes in technology and or phone terminology.
[Email]	Bracketed to accommodate changes in technology and or phone terminology.
[Employer Name [Work Phone Number] Employer Address (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Beneficiary's Full Name Relationship Beneficiary's Address (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Billing Address *if different than residence* (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Is the Applicant's household income [$15,000] per year or more?] Ranges [If "No", the Proposed Insured is not eligible for coverage.]	Bracketed to allow the amount to be adjusted up or down depending on the economy and business decision at the time. $10,000 - $50,000 Questions may be included or excluded based on plan offered.
Within the last [12] months, has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe, or used nicotine or tobacco products?	6 or 12
QUALIFICATION QUESTIONS Question #1: [10 years] Question #2: [10 years] Question #3: [10 years] Question #4: [6 months] [5. [Within the past [6 months] has the Proposed Insured Submitted an application for [life][or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	Bracketed material is dependent on the plan design that will be marketed to individuals. 5 to 10 years 5 to 10 years 5 to 10 years 6 to 24 months Question #5 is bracketed to allow for company decision to include or not include question #5 dependent on plan design that will be marketed to individuals. Only one version of the application will be used within the same

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A Chubb Company

[6 months] [life] [or] [critical illness]	timeframe. 3 months to 2 years Bracketed item will either be included or excluded. Bracketed item will either be included or excluded.
[**UNDERWRITING INFORMATION** Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes No **[If "Yes", please provide details below:** Medical/Diagnostic Test Diagnosis Treatment Dates Physician Name/ Address/Phone No.]]	Bracketed to allow for company decision to include or not include underwriting information dependent on plan design that will be marketed to individuals. Only one version of the application (either with or without the bracketed information) will be used within the same timeframe.
COVERAGE TYPE [☐ Choice] [XXXXX][XXX] [☐ Preferred] [XXXXX][XXX]	Bracketed to allow for company decision to remove or add Plans if not needed for business operations.
Payment Method [☐ Bi-weekly EFT] [☐ Monthly EFT] [☐ Quarterly EFT] [☐ Semi-Annual EFT] [☐ Annual Bill] [☐ Monthly Credit Card] [☐ Quarterly Credit Card] [☐ Semi-Annual Credit Card] [☐ List Bill] [☐ Other]	Bracketed to allow for the removal of one or more modal options.
PLEASE READ CAREFULLY [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]	 Bracketed information will either be included or excluded.
[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]	Bracketed for the removal of this statement when the application is not taken by electronic or telephonic means.

[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]	Bracketed for the removal of this statement when the application is not taken by electronic means.
Agent Authorization Section	Bracketed to allow for removal of this section when application is taken electronically via the Internet or by Direct Response.

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VARIABILITY MEMORANDUM
Individual Cancer Only Application Form

Application Form No. 146700R	
Home Office: [Chicago, Illinois]	Bracketed address to alleviate a future filing of these forms if the company addresses change.
[Language Preference [☐E] [☐S] [☐F]	
Action Requested: [New Policy], [Policy Change,] [Reinstatement]]	Bracketed to allow for company decision to remove if not needed for business operations.
[Landline Phone No.]	Bracketed to accommodate changes in technology and or phone terminology.
[Mobile Phone No.]	Bracketed to accommodate changes in technology and or phone terminology.
[Email]	Bracketed to accommodate changes in technology and or phone terminology.
[Employer Name [Work Phone Number] Employer Address (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Beneficiary's Full Name Relationship Beneficiary's Address (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Billing Address *if different than residence* (Street) City State ZIP]	Bracketed to allow for company decision to include or exclude the information.
[Is the Applicant's household income [$15,000] per year or more?] Ranges [If "No", the Proposed Insured is not eligible for coverage.]	Bracketed to allow the amount to be adjusted up or down depending on the economy and business decision at the time. $10,000 - $50,000 Questions may be included or excluded based on plan offered.
In the last [12] months, has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe, or used nicotine or tobacco products?	6 or 12
QUALIFICATION QUESTIONS Question #1: [10 years] Question #2: [10 years] Question #4: [6 months] [4. [Within the past [6 months] has the Proposed Insured Submitted an application for [cancer] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	Bracketed material is dependent on the plan design that will be marketed to individuals. 5 to 10 years 5 to 10 years 6 to 24 months Question #4 is bracketed to allow for company decision to include or not include question #4 dependent on plan design that will be marketed to individuals. Only one version of the application will be used within the same timeframe.

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A Chubb Company

[6 months] [cancer]	3 months to 2 years Bracketed item will either be included or excluded.
[**UNDERWRITING INFORMATION** Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes No **[If "Yes", please provide details below:** Medical/Diagnostic Test Diagnosis Treatment Dates Physician Name/ Address/Phone No.]]	Bracketed to allow for company decision to include or not include underwriting information dependent on plan design that will be marketed to individuals. Only one version of the application (either with or without the bracketed information) will be used within the same timeframe.
COVERAGE TYPE [☐ Choice]	Bracketed to allow for company decision to remove or add Plans if not needed for business operations.
Payment Method [☐ Bi-weekly EFT] [☐ Monthly EFT] [☐ Quarterly EFT] [☐ Semi-Annual EFT] [☐ Annual Bill] [☐ Monthly Credit Card] [☐ Quarterly Credit Card] [☐ Semi-Annual Credit Card] [☐ List Bill] [☐ Other]	Bracketed to allow for the removal of one or more modal options.
PLEASE READ CAREFULLY [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]	 Bracketed information will either be included or excluded.
[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]	Bracketed for the removal of this statement when the application is not taken by electronic or telephonic means.
[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]	Bracketed for the removal of this statement when the application is not taken by electronic means.

Agent Authorization Section	Bracketed to allow for removal of this section when application is taken electronically via the Internet or by Direct Response.

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[Bar Code] [Application Number] **[5 9 0 1]**

COMBINED INSURANCE COMPANY OF AMERICA

Home Office: [Chicago, Illinois]

Application for Critical Illness Coverage

[LANGUAGE PREFERENCE [☐ E] [☐ S] [☐ F]]

I am applying for this coverage based on the following information:

(Home Office Use)

[ACTION REQUESTED: **[** ☐ New Policy] [☐ Policy Change] [☐ Reinstatement]]

Proposed Insured's Name (First MI Last)	☐ Male ☐ Female	Birthdate: MM/DD/YYYY	Age
Proposed Insured's Home Address (Street)	City	State	Zip
[Landline Phone Number] [Mobile Phone Number]	[Email]		
Employer Name	[Work Phone Number]		
Employer Address (Street)	City	State	Zip
Beneficiary's Full Name		Relationship	
Beneficiary's Address (Street)	City	State	Zip
Billing Address *if different than residence (Street)*	City	State	Zip

Will this policy replace any existing policies for the Proposed Insured? ☐ Yes ☐ No

[Is the Proposed Insured's household income [$15,000] per year or more? ☐ Yes ☐ No]
[If "No", the Proposed Insured is not eligible for coverage.]

In the past [12 months], has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine or tobacco products? ☐ Yes ☐ No	Height _____FT. ___IN.	Weight _____LBS.

QUALIFICATION QUESTIONS:

I represent that the answers to the below questions are accurate and complete to the best of my knowledge and belief.

	Yes	No
1. Within the past [10 years], has the Proposed Insured received any medical advice or treatment from a member of the medical profession, or taken any prescription medicine for:		
a. Heart failure, angina, stroke, transient ischemic attack, heart attack, chronic atrial fibrillation, coronary artery disease that required angioplasty or stent placement, heart valve repair or replacement?	☐	☐
b. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?		
c. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?	☐	☐
d. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?	☐	☐
e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?	☐	☐
f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction?	☐	☐
g. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?	☐	☐
2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?	☐	☐
3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole, incarcerated or convicted of a felony?	☐	☐
4. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?	☐	☐
5. [Within the past [6 months] has the Proposed Insured submitted an application for [life,] [or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	☐	☐

If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.

UNDERWRITING INFORMATION

	Yes	No
Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?	☐	☐

If "Yes", please provide details below:

Medical/Diagnostic Test	Diagnosis	Treatment	Dates	Physician Name/ Address/Phone No.

PLAN SELECTION

COVERAGE TYPE	*FACE AMOUNT* *(up to $50,000)*	*PAYMENT METHOD*	*PREMIUM AMOUNT*
[☐ Choice] [XXXXX] [XXX] [☐ Preferred] [XXXXX] [XXX]	$	[☐ Bi-weekly EFT] [☐ Monthly Credit Card] [☐ Monthly EFT] [☐ Quarterly Credit Card] [☐ Quarterly EFT] [☐ Semi-Annual Credit Card] [☐ Semi-Annual EFT] [☐ List Bill] [☐ Annual Bill] [☐ Other]	$

DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.

[2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

~~*If coverage applied for includes Sickness Rider, please complete the attestation below. (If the Proposed Insured checks "No", the Sickness Rider will not be issued.).*~~

NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? ☐ Yes ☐ No

If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.

(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? ☐ Yes ☐ No

(3) Do you understand that the benefits provided under this policy may be limited? ☐ Yes ☐ No

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]

X _____ _____ _____ _____
Signature of Proposed Insured | City | State | Date

I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me by the Proposed Insured, or have sent this application to the Proposed Insured and have received the completed and signed application on this date.

X _____ _____ _____
Signature of Licensed Agent/Producer | Agent Code | Date of Application

[Bar Code] [Application Number] **[6 1 0 1]**

COMBINED INSURANCE COMPANY OF AMERICA
Home Office: [Chicago, Illinois]

Application for Cancer Only Coverage
[LANGUAGE PREFERENCE [☐ E] [☐ S] [☐ F]]

I am applying for this coverage based on the following information:

(Home Office Use)

[ACTION REQUESTED: **[** ☐ New Policy] [☐ Policy Change] [☐ Reinstatement]]

Proposed Insured's Name (First MI Last)	☐ Male ☐ Female	Birthdate: MM/DD/YYYY	Age
Proposed Insured's Home Address (Street)	City	State	Zip
[Landline Phone Number] [Mobile Phone Number]	[Email]		
Employer Name	[Work Phone Number]		
Employer Address (Street)	City	State	Zip
Beneficiary's Full Name		Relationship	
Beneficiary's Address (Street)	City	State	Zip
Billing Address *if different than residence (Street)*	City	State	Zip

Will this policy replace any existing policies for the Proposed Insured? ☐ Yes ☐ No

[Is the Proposed Insured's household income [$15,000] per year or more? ☐ Yes ☐ No]
[If "No", the Proposed Insured is not eligible for coverage.]

In the past [12 months], has the Proposed Insured smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine or tobacco products? ☐ Yes ☐ No	Height _____FT. ___IN.	Weight _____LBS.

QUALIFICATION QUESTIONS:
I represent that the answers to the below questions are accurate and complete to the best of my knowledge and belief.

	Yes	No
1. Within the past [10 years], has the Proposed Insured received any medical advice or treatment from a member of the medical profession, or taken any prescription medicine for:		
a. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?	☐	☐
b. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?	☐	☐
c. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?	☐	☐
d. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?	☐	☐
e. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?	☐	☐
2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?	☐	☐
3. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?	☐	☐
4. [Within the past [6 months] has the Proposed Insured submitted an application for [Cancer] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]	☐	☐

If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.

[Bar Code] [Application Number] [6 1 0 2]

UNDERWRITING INFORMATION

Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes ☐ No ☐

If "Yes", please provide details below:

Medical/Diagnostic Test	Diagnosis	Treatment	Dates	Physician Name/ Address/Phone No.

PLAN SELECTION

COVERAGE TYPE	*FACE AMOUNT* *(up to $50,000)*	*PAYMENT METHOD*	*PREMIUM AMOUNT*
[☐ Choice] 16738 ECA	$	[☐ Bi-weekly EFT] [☐ Monthly EFT] [☐ Quarterly EFT] [☐ Semi-Annual EFT] [☐ Annual Bill] [☐ Monthly Credit Card] [☐ Quarterly Credit Card] [☐ Semi-Annual Credit Card] [☐ List Bill] [☐ Other]	$

DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.

[2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

~~*If coverage applied for includes Sickness Rider, please complete the attestation below. (If the Proposed Insured checks "No", the Sickness Rider will not be issued.).*~~

NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? Yes ☐ No ☐

If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.

(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? Yes ☐ No ☐

(3) Do you understand that the benefits provided under this policy may be limited? Yes ☐ No ☐

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[☐ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]

X _____ _____ _____ _____
Signature of Proposed Insured | City | State | Date

I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me by the Proposed Insured, or have sent this application to the Proposed Insured and have received the completed and signed application on this date.

X _____ _____ _____
Signature of Licensed Agent/Producer | Agent Code | Date of Application